COUNTY REVIEW TEAM REPORT ON THE FATALITY OF:

GRACE PACKER

Date of Birth: 8-14-01

Date of Death: 7-9-16

Date of Report to ChildLine: 1-9-17

FAMILY KNOWN TO:

Berks County Children & Youth Services
Burke County, NC Department of Social Services
Delaware County Children & Youth Services
Lehigh County Office of Children & Youth Services
Montgomery County Office of Children & Youth

FAMILY NOT KNOWN TO:

Bucks County Children & Youth Social Services Agency

SUBMITTED BY:

Bucks County Children & Youth Social Services Agency
Montgomery County Office of Children & Youth

Reason for Review:

Pursuant to the Child Protective Services Law (CPSL), county children and youth agencies must convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

The local review team must submit a final written report on each child fatality or near fatality to the OCYF Regional Office and designated county officials consistent with §6340 (a) (11) of the CPSL within 90 days of convening the County Fatality and Near Fatality Review Team.

BUCKS AND MONTGOMERY COUNTIES jointly convened their review teams in accordance with the CPSL related to this report. The initial review team meeting was convened on February 6, 2017 and a follow-up meeting was held on April 21, 2017 to provide additional time for attendees to review recommendations.

Family Constellation:

Name:	Relationship:		Date of Birth:
[redacted]	Mother		1975
[redacted]	Father		1976
[redacted]	Paramour		1972
Grace Packer	Child		08-14-2001
[redacted]	Child		2004
[redacted]	Sibling		1998
[redacted]	Paternal	Grandmother	1945
[redacted]	Paternal	Grandfather	1944
[redacted]	Paternal	Cousin	1988
[redacted]	Paternal	Cousin	1986

*Not members of the household, or did not live in the home at the time of the incident.

Summary of County Child Fatality Review Team Activities:

The Fatality Teams from both Bucks and Montgomery Counties jointly met on February 6, 2017, to review all county child welfare involvement and the services provided to the [redacted] family. The following is a list of those present at the review:

[redacted] President, CEO, Impact Project
[redacted] Act 33 Chairperson, Lehigh County Office of Children & Youth Services
[redacted] Northampton County Children, Youth & Families
[redacted] Associate Director, Network of Victim Assistance, Bucks County
[redacted] Clinician, Valley Youth House
[redacted] Montgomery County Detective Bureau
[redacted] Director, Lehigh County Office of Children & Youth Services
[redacted] Act 33 Chairperson, Bucks County Children & Youth
[redacted] Social Worker, Bucks County Children & Youth
[redacted] Director, Bucks County Child Advocacy Center
[redacted] Director, Northampton County Children & Youth
[redacted] Director of Social Services, Montgomery County Office of Children & Youth
[redacted] Director, Bucks County Mental Health & Developmental Programs
[redacted] Assistant Director, Bucks County Human Services
[redacted] Fiscal Officer, Bucks County Children & Youth
[redacted] Social Worker, Bucks County Children & Youth
[redacted] Solicitor, Berks County Children & Youth Services
[redacted] Bucks County Detectives
[redacted] Children's Services Coordinator, Bucks County Mental Health &Developmental Programs
[redacted] Abington Police Department
[redacted] Program Supervisor, Valley Youth House
[redacted] Supervisor, Southeast Region, Office of Children, Youth & Families
[redacted] Solicitor, Bucks County Children & Youth
[redacted] Executive Director, Pinebrook Family Answers
[redacted] Montgomery County Health Department
[redacted] Program Representative, Southeast Region, Office of Children, Youth & Families
[redacted] Regional Director, Northeast Region, Office of Children, Youth & Families
[redacted] Supervisor, Bucks County Children & Youth
[redacted] Administrator, Berks County Children & Youth
[redacted] Assistant Director, Bucks County Children & Youth
[redacted] Program Specialist, Bucks County Children & Youth
[redacted] Program Improvement Administrator, Montgomery County Office of Children & Youth
[redacted] Senior Vice-President, Valley Youth House
[redacted] Bucks County Detectives
[redacted] Supervisor, Bucks County Children & Youth
[redacted] Program Representative, Southeast Region, Office of Children, Youth & Families
[redacted] Director, Montgomery County Mission Kids
[redacted] Director, Montgomery County Office of Children & Youth

[redacted] Director, Montgomery County Health & Human Services
[redacted] Abington Police Department
[redacted] Assistant Director, Delaware County Children & Youth
[redacted] Director, Bucks County Children & Youth
[redacted] Social Worker, Bucks County Children & Youth
[redacted] Lehigh County Children & Youth
[redacted] Director, Bucks County Drug & Alcohol Commission
[redacted] Director, Bucks County Human Services
[redacted] Act 33 Chairperson, Montgomery County Office of Children & Youth
[redacted] Montgomery County Behavioral Health & Office of Developmental Disabilities
[redacted] Director of Social Services, Pinebrook Family Answers
[redacted] Director, Southeast Region, Office of Children, Youth & Families
[redacted] Lehigh County Office of Children & Youth Services
[redacted] Delaware County Children & Youth
[redacted] Assistant Director, Montgomery County Mission Kids
[redacted] Montgomery County Behavioral Health & Office of Developmental Disabilities
[redacted] Intake Administrator, Montgomery County Office of Children & Youth
[redacted] Placement Manager, Bucks County Children & Youth
[redacted] Assistant Solicitor, Montgomery County Office of Children & Youth
[redacted] Intake Manager, Bucks County Children & Youth
[redacted] Executive Director, Impact Project
[redacted] Director, Project Child
[redacted] Bucks County Detectives
[redacted] Supervisor, Northeast Region, Office of Children, Youth & Families
[redacted] District Attorney, Bucks County
[redacted] Intake/Child Protective Services Manager, Bucks County Children & Youth

The case history was reviewed and each county presented their case involvement. The police and county detectives described their investigation to date. A timeline was presented outlining dates of involvement by each county agency and the dates of significance in Grace's life prior to and after the [redacted] by the [redacted]

Following this Fatality Review meeting a team of 4 members was formulated, consisting of the two ACT 33 Chairpersons and two Bucks and Montgomery County Child Welfare administrators. **Due to extensive expungement of reports and case records, this Team was limited in their ability to review critical materials.**

The Team reviewed the following records:

- Berks County child welfare case record, except for case notes

- Lehigh County child welfare case record
- Montgomery County "Law Enforcement Only (LEO)" and ChildLine reports
- Burke County, N.C. child welfare case records
- Abington School District Records
- [redacted] care reports (found in child welfare case records)
- [redacted] records for Grace
[redacted] records for Grace and [redacted]
- [redacted] homestudy
- ChildLine available history

Records were reviewed on 2/16/17; 2/21/17; 3/8/17; 3/21/17, 4/3/17, 4/27/17, and 5/25/17.

The team requested but could not obtain the following records:

- ChildLine expunged history/records
- Northeast Region Office of Children, Youth & Families (OCYF) investigative data which was reported to be expunged
- Berks County case notes which were reported to be expunged
- [redacted] records which were reported to be expunged
- [redacted] records which were reported to be expunged

The team interviewed the following key persons involved with this family:

- [redacted], former Lehigh County Child Welfare Caseworker and at the time of the interview was a Bucks County Child Welfare Caseworker
- [redacted], Senior Case Manager, [redacted]
- [redacted], Berks County Caseworker
- [redacted], former Berks County Caseworker
- [redacted], Berks County Solicitor
- [redacted], [redacted] Evaluator, [redacted], Co-Evaluator, [redacted]
- [redacted], Burke County, N.C. Program Manager
- [redacted], Lehigh County Child Welfare Supervisor
- [redacted], Lehigh County Child Welfare Caseworker
- [redacted], Lehigh County Child Welfare Director

All of the above interviews occurred on 4/7/2017, with the exception of [redacted], which occurred on 4/21/2017.

The team attempted to interview the following persons:

- [redacted], [redacted]—was no longer with the agency

- [redacted]—no longer with the agency
- [redacted], [redacted]—no longer with the agency
- [redacted], Northeast Regional Office, OCYF, no longer with Northeast Regional Office
- Any current staff from Northeast Regional Office, OCYF

A second review meeting with both County Fatality Teams occurred on 4/21/17 to allow time for a discussion of findings from the record reviews and interviews. At this time the team members were able to ask questions and formulate recommendations.

Children and Youth Involvement Prior to Incident:

April 1999-2000

[redacted] began dating [redacted] and the two cohabitated beginning in September 1999. In December of 1999, they were engaged to be married. In July of 2000, [redacted] became licensed [redacted] parents through the [redacted], [redacted] During their involvement with [redacted], they [redacted] approximately fifty children. [redacted] were married during the month of September 2000.

February 2002- January 2003
Montgomery County Office of Children & Youth (MCOCY)

February 20, 2002

The [redacted] family ([redacted] of [redacted], Grace [redacted] [redacted]—Grace and [redacted] were formerly known as [redacted] was referred to MCOCY due to [redacted] housing conditions, safety violations, criminal and drug activity. The family was given 24 hours to remediate the concerns; however, they were unable to do so. MCOCY opened case for assessment and services.

February 22, 2002

[redacted] custody of [redacted] and [redacted] Grace, DOB (8/14/2001). [redacted] placed in [redacted] care.

March 4, 2002

MCOCY learned the [redacted] family secured a new residence in Pottstown, PA. On March 6, 2002, an [redacted] The residence was deemed safe by MCOCY, the children were returned to the [redacted] on March 14, 2002, and [redacted] custody of the children were returned to the

[redacted] on April 2, 2002. MCOCY implemented in-home services through [redacted]

September 2002
The [redacted] initiated the process to obtain [redacted] housing in Berks County. During the month of December 2002, the [redacted] secured housing in Reading, Berks County.

December 29, 2002
Grace was seen due to a [redacted], abuse was not suspected and parenting classes were recommended to occur at [redacted]

January 3, 2003
MCOCY confirmed the [redacted] family moved to Berks County, and a formal referral was made to Berks County Children & Youth by MCOCY. The family's case was closed in Montgomery County. MCOCY completed a [redacted]
Per MCOCY's recommendations, [redacted] and Grace were to have no contact with [redacted]

January 2003- March 2007
Berks County Children & Youth Services (BerksCCYS)

January 6, 2003
The [redacted] case was transferred from MCOCY to BerksCCYS. BerksCCYS accepted the case and opened it for services. The [redacted] were provided several community based services to assist with parenting, housekeeping, child development, education, [redacted], services for the parents, [redacted] and hospice for [redacted] who resided in the home.

September 2003
Mr. [redacted] was removed from the home for several days due to domestic violence issues. Mrs. [redacted] was referred to [redacted] Services for [redacted]; however, she did not follow through. [redacted] Services provided intensive independent living services from May-October 2003. The [redacted] compliance was inconsistent and concerns remained regarding the [redacted] ability to provide appropriate care for their children.

January 2003
[redacted] began working for Northampton County Children & Youth.

January 28, 2004
The [redacted] participated in a non-offender evaluation through [redacted], prompted by MCOCY's [redacted], in order to evaluate their ability to protect the children and prevent [redacted]. According to the evaluation, the [redacted] were deemed unable to provide adequate protection. The [redacted] was pregnant with [redacted] at that time.

February 27, 2004
BerksCCYS [redacted] of [redacted] Grace[redacted] and placed them in [redacted].

February 27, 2004-October 5, 2004
[redacted] Grace[redacted] were placed in three consecutive [redacted] placements through [redacted]. [redacted] exhibited an inconsistent adjustment at the [redacted] homes. At the third [redacted] home, [redacted] acted out [redacted]

May 12, 2004
[redacted] was taken into [redacted] custody on this date based on concerns surrounding the lack of appropriate supervision and the [redacted] inability to provide appropriate protection [redacted]

May 19, 2004
[redacted] Grace[redacted] & [redacted] were [redacted] to BerksCCYS.

October 5, 2004
[redacted] Grace[redacted] were all placed in the home of [redacted] in Allentown, PA

July 24, 2005 & August 5, 2005
[redacted] Grace[redacted] was seen for a [redacted] evaluation [redacted] which was recommended due to concerns she was sexually molested. [redacted] Grace[redacted] presented as [redacted] for her age and it was believed, as a result of the evaluation, she was [redacted]. However, the perpetrator of the abuse was unknown. It was recommended that [redacted] Grace[redacted] be supervised around children [redacted] was also recommended.

August 4, 2005
BerksCCYS filed [redacted]

December 2005
[redacted] Home Study (Completed by [redacted]) of the [redacted] home resulted in the recommendation to approve the [redacted] Grace[redacted]

January 28, 2006
[redacted] was removed from the home and placed in respite care with [redacted] from 1/30/2006-2/20/2006.

February 20, 2006
[redacted] returned to the [redacted] home.

April 5, 2006
[redacted] was touching and hitting [redacted]. [redacted] put alarms on doors in home. [redacted]

May 22, 2006-June 6, 2006
[redacted] to exhibiting aggressive behaviors.

June 5, 2006
Parental rights of the [redacted]

July 10- July 20, 2006
[redacted]

July 20, 2006--November 10, 2006
[redacted] resided in the [redacted] home of [redacted]

September 28, 2006
[redacted] wrote a three-page letter regarding the decision of Berks CCY to suspend [redacted]. In the letter, [redacted] expressed frustration toward Berks County's reaction to [redacted] making an allegation that she was fearful to return home. [redacted] expressed feeling as though she and [redacted] were being punished and the [redacted] of [redacted] Grace [redacted] was being stalled due to [redacted] lack of progress in [redacted].

October 5, 2006
During [redacted] expressed fear of [redacted]. The case record stated that [redacted] reported that [redacted] should seek professional assistance before completing the [redacted] as [redacted] did not believe them to exhibit appropriate parenting skills.

March 16, 2007
[redacted] Grace [redacted] were [redacted]

February 2007- December 2009
Delaware County Children & Youth Services (DCCYS)

February 2007
[redacted] was placed in [redacted] with [redacted]. Initially, [redacted] struggled; however, her disposition began to improve. The [redacted] requested for [redacted] to stay indefinitely and a plan for [redacted] was pursued. [redacted] disposition began to deteriorate as she was having conflict with [redacted], leaving the home absent permission, associating with inappropriate peer groups, and skipping school. On October 10, 2007, [redacted] discovered that [redacted]

February 5, 2007
[redacted] made accusations against another [redacted] child in the home. [redacted]. [redacted] admitted it and said it was because another [redacted] child was doing it to her. That child was removed, and [redacted] went into respite care for one night.

October 11- October 23, 2007
[redacted]

October 23, 2007
[redacted] was ultimately returned to the [redacted] home. She initially adjusted; however, her adjustment declined. The [redacted] asked for a 30-day removal. On January 10, 2008, [redacted] ran away from the [redacted] home. Upon her return, [redacted]. was taken to the [redacted] and transferred to [redacted]. [redacted] treatment was recommended and [redacted] was transferred to [redacted] on February 6, 2008. The [redacted] remained in contact, and [redacted] returned to the [redacted] home.

June 16, 2009
DCCYS finalized [redacted]. [redacted] turned 18-years-old on [redacted], and the [redacted] [redacted] ended.

May 2007- September 2012
Lehigh County Office of Children & Youth (LCOCY)

May 30, 2007—Referral*
Lehigh County (LCOCY) completed a courtesy interview request for [redacted] child, who resided in the [redacted] home. Allegations of sexual abuse [redacted] OCYF Northeast Regional Office investigated; closed November 2007. [redacted]; no records available to review.

May 2, 2008—Referral*
Allegations that [redacted] spanked Grace with a wooden spoon [redacted] Grace reported that she had difficulty sitting. Despite these allegations, Northeast Regional Office OCYF [redacted]. The Region asked that no other children be placed in the [redacted] home. [redacted]; no records available to review.

November 5, 2008—Referral*
Allegations of failure to seek appropriate medical care and follow-up for a [redacted] child with [redacted] Referral was a [redacted] assessment which was [redacted]; no records available to review.

January 19, 2010—Referral*
Allegations of sexual abuse against [redacted] child [redacted]. Seventeen-year-old foster child stated [redacted], and

foster child believed she was going to be [redacted]. OCYF Northeast Regional Office investigated. [redacted] were referred for forensic evaluations at [redacted] Services.

January 19, 2010
Safety plan was developed by the Northeast Regional Office and Lehigh County Intake worker and implemented without court involvement. Grace went to live with [redacted] on an informal arrangement, and [redacted] went to [redacted] pending the outcome of the [redacted].

January 2010
[redacted] immediately closed the [redacted] home.

[redacted] employment was terminated at Northampton County Children & Youth.

March 3, 2010
A new safety plan was implemented allowing [redacted] supervised visitation with Grace and [redacted]. Visitation was supervised by [redacted].

March 10, 2010
Both [redacted] refused to sign Family Service Plan.

March 2010 to June 2010
[redacted] completed a [redacted] evaluation on both [redacted] admitted that Grace [redacted] for about six years, and that [redacted] minimized Grace's [redacted]. [redacted] described the sexual contact with the [redacted] child as an affair, and that he knew he was wrong [redacted]. [redacted] stated that when [redacted] was five years old, she accused him of sexual abuse, but he claimed it was untrue. [redacted]

[redacted] acknowledged viewing pornography and engaging in experimental sex with her husband before they had children, and stated there was never any pain or trauma during these activities. [redacted] had photographs of a 17-year-old [redacted] child with her hands tied and holding a rope and said it was for a Goth clothing line that [redacted] was starting. [redacted] admitted to engaging in sex with her husband and a [redacted] daughter. [redacted] claimed that she thought the age of consent was 16 years of age and that she did not know CPS law. [redacted] stated that she was uncertain if [redacted] had abused Grace, and she voiced ambivalence regarding [redacted] relationship with Grace. [redacted] also stated that she did not have the strength to deal with [redacted] having sex with the [redacted] child and viewed it as a consensual relationship.

Despite [redacted] admitted active engagement of sexual abuse of a [redacted] child in her home, and being [redacted] for those allegations, she was referred by Lehigh County to non-offending parent [redacted] at [redacted]

[redacted]

May 19, 2010 & June 10, 2010

[redacted] report listing [redacted], victim child's name was [redacted]

June 8, 2010—Referral*

Allegations that [redacted] was watching pornography with Grace. Grace was interviewed at [redacted], where she denied the allegations of watching pornography, but stated that [redacted] unzipped his pants and asked Grace to touch his penis on several occasions. Grace also stated [redacted]. [redacted] admitted this to the police. [redacted] were observed to be hostile towards Grace [redacted]. Grace had been placed with [redacted] who were hostile toward her, did not believe her, and blamed her for [redacted] arrest. No contact clause reinstated for [redacted] with Grace and [redacted]. [redacted] evaluations were completed on [redacted] through [redacted] New safety plan initiated; no contact with [redacted] for Grace and [redacted]. [redacted] to assure no contact when children return home.

[redacted]

June 29--July 3, 2010

Grace [redacted] as a result of [redacted] concerns and [redacted] struggling to provide care.

[redacted]

[redacted]

July 19, 2010 (Approximately)

[redacted] moved out of the family home leaving [redacted] to be available as a resource for the children. [redacted] returned home to [redacted]

[redacted]

[redacted]

August 19, 2010
Grace was discharged from [redacted] and returned home to [redacted] with Family Based Services through [redacted]

September 23, 2010
[redacted] arrested and charged for the following crimes associated with Grace and [redacted]

- Grace--Indecent Assault of Person less than 13 years of age, Misdemeanor 1 waived for Court; later replaced with Indecent Assault of Person less than 13-Felony 3, combined with [redacted] Hearing--guilty plea negotiated.
- [redacted] Statutory Sexual Assault Felony 2--guilty plea negotiated, Involuntary Deviate Sexual Intercourse Person less than 16 years of age--Felony 1, later withdrawn, Corruption of Minors Misdemeanor 1--later withdrawn.
- Sentence: State Correctional Institution 6 months to 3 years. [redacted] was deemed a sexually violent predator under Megan's Law.

[redacted]

October 14, 2010
[redacted] refused to sign Family Service Plan.

November 24, 2010
[redacted] began to become uncooperative, and [redacted] was not scheduling home visits with the county.

February 9, 2011
[redacted] had difficulty cutting ties with [redacted].

June 8, 2011
[redacted]

December 5, 2011
[redacted]

[redacted]

April 23, 2012
[redacted] said that [redacted] needed to take responsibility to keep her "ex-husband" out of the house.

September 2012
LCOCY closed case with [redacted] family.

September 2012--November 2015
Post Lehigh County Children & Youth (LCCY)

October 2012
[redacted]

2012 (Approximate)
[redacted] and [redacted] met and moved in together.

April 23, 2013
Grace reportedly attempted to stab [redacted] with a screwdriver during [redacted] conflict. [redacted]

June 19, 2013
Grace [redacted]. [redacted] reported that [redacted] was a victim of severe domestic violence (physical, emotional, & financial) during [redacted] relationship with [redacted] In previous reports, [redacted] denied any domestic violence or abuse. [redacted] also focused on the impact of the domestic violence on [redacted] relationship with Grace [redacted]. Grace maintained largely appropriate conduct (incongruent between [redacted] reported conduct of and what is observed of Grace on the [redacted]

August 15, 2013
[redacted] and [redacted] moved to Harleysville, Montgomery County.

[redacted]

December 13, 2013- June 2014
Grace returned home [redacted]

December 2013 to June 2014
Grace attended an alternative school in [redacted]

June 25, 2014
Grace admitted to [redacted] as a result of suicidal ideation.

June 26, 2014
Law Enforcement Only (LEO) report to Montgomery County Office of Children & Youth regarding Grace [redacted] being inappropriate with [redacted] Report was listed to be an LEO [redacted]

June 26, 2014
[redacted] Police received a report [redacted] Police contacted [redacted] to discuss the [redacted] report. [redacted] advised that the sexual incidents disclosed took place in 2011 and were already investigated. [redacted] stated that [redacted] children had received [redacted] and no other incidents had occurred. [redacted]

July 14, 2014
[redacted] Police contacted the Montgomery County Detective Bureau to provide an update on the status of the investigation, and that [redacted] Police would not be conducting any further investigation into the allegations.

July 30, 2014
Grace was admitted to [redacted] indicated that she was not able/willing to have Grace continue to reside with [redacted] looked into the [redacted] as resources at [redacted] request; however, the [redacted] provided [redacted] ([redacted] relatives/cousins), who resided in [redacted], as options. [redacted] visited Grace at [redacted] and [redacted] signed "guardianship" over to the [redacted] did not involve the county child welfare system in making any of the discharge arrangements for Grace.

November 2014 (Approximate)
[redacted] who moved in with [redacted]

November 2014
[redacted] moved to Roslyn, Montgomery County, with [redacted]. Living in the residence at that time were: [redacted] Grace, [redacted].

April 11, 2015
[redacted] moved to Glenside, Montgomery County, with [redacted]

January 2015-December 2015
Burke County, North Carolina, Department of Social Services (BCDSS)

January 18, 2015
Grace was discharged from [redacted] and moved to Burke County, North Carolina to reside with [redacted] Grace remained in [redacted] legal custody. [redacted] authorized permissions via notarized letter.

Per [redacted], Grace attended [redacted] (alternative school/8th grade), [redacted] in August 2015 for 9th grade, and received [redacted] and [redacted] through [redacted]. [redacted] did not have contact with Grace during her time in North Carolina. On November 11, 2015, [redacted] contacted the Burke County Department of Social Services (BCDSS) to discuss the incidents and requested help and potential placement options. BCDSS visited the home and informed [redacted] that the custody paperwork she had from [redacted] was not legal and that Grace was to return to [redacted]

November 20, 2015
BCDSS received a report from [redacted] involving Grace Packer. [redacted] reported she was unable to care for Grace [redacted] also reported that she was unable to reach [redacted] because [redacted] had moved without providing any forwarding information. BCDSS contacted [redacted] (after completing searches for [redacted] phone number and eventually finding [redacted] on FaceBook), and [redacted] agreed to pick up Grace.

On November 20, 2015, Grace reported to her Burke County Caseworker that she was not safe at home, would end up in a hospital for a long time because she could not "keep herself together," Grace was afraid of her [redacted] father, said he hurt her when she was little, but he was in jail now and she had no contact. Grace also reported that [redacted] was abusive to her, slapping her in the face and lying about it. Grace's [redacted] reported to Burke County that she felt that Grace was a flight risk as she did not want to return to live with [redacted]

As the [redacted] felt they could no longer care for Grace, [redacted] contacted a [redacted] Grace, where Grace

stayed until [redacted] picked her up a few days later. Ms. [redacted] reported that [redacted] witnessed Grace screaming, crying, hitting her head against the car window, and refusing to get into the car until [redacted] physically pushed her into the car.

November 23, 2015
BCDSS received a call from [redacted] stating that Grace was picked up by [redacted] and returned to Pennsylvania.

November 25, 2015
Montgomery County Office of Children & Youth (MCOCY) received a telephone call from BCDSS, after Grace returned to [redacted], to request that a visit be made to the [redacted] home now that Grace had returned, per their required protocol to close the case. [redacted]

MCOCY responded to Burke County that without current concerns/maltreatment, a home assessment would not be conducted. The MCOCY screening worker indicated that the local police department could assist with a welfare check of the child and family. MCOCY provided BCDSS contact information for Abington Township Police Department. BCDSS placed a call to Abington Township Police to request a well-check on Grace. Abington Township Police agreed to check on Grace and to call back the worker with the outcome. BCDSS contacted [redacted] letting her know that the police would conduct a well-check on Grace prior to closing the case.

November 25, 2015
Abington Police Department completed a well-check and reported that Grace seemed okay although they noted a large number of individuals in the home.

December 16, 2015
BCDSS closed their case.

December 2015-November 2016
Post Burke County Department of Social Services

November 25, 2015- June 22, 2016
Grace began receiving [redacted] and [redacted] at [redacted] Primary concerns noted were a history of sexual abuse, [redacted], and emotional instability. [redacted] initiated the [redacted] for Grace and was the primary historian. Grace completed 21 sessions. On March 9, 2016, Grace reported to the [redacted] that she used a student's tablet to make an email and FaceBook account. [redacted] Upon discovery, [redacted] removed the majority of Grace's belongings from her room. [redacted] informed Grace she was no longer part of the family, stated that she was not allowed to talk to anyone, and was not to leave her

room unless she was going to school or [redacted] The last session at [redacted] occurred on June 22, 2016. The focus of the session involved Grace being unhappy with having to move to Quakertown and not being able to see friends. Grace expressed frustration with [redacted] for calling her a prisoner. A next session was scheduled for June 29, 2016. [redacted] cancelled the June 29th session stating Grace was sick.

December 2015 to June 2016
Grace attended Abington School District in Montgomery County and was placed in an [redacted] where she met daily for breakfast with a [redacted] for "check-ins." The [redacted] counselor also met sporadically with Grace individually, as well as, when Grace would have issues with peers. In March 2016, Grace informed her [redacted] counselor that she got in trouble at home and her punishment was: only allowed to wear sweat pants, not allowed to wear make-up or jewelry, and not allowed to participate in Friday night pizza dinner (which was her favorite thing to do). Following that conversation with the [redacted] counselor, a letter was found by the Assistant Principal and Special Educational Services Supervisor which appeared to be a "goodbye" letter. The letter was given to the [redacted] counselor who was told to address it with Grace. Grace denied being suicidal, and said she was being placed back into [redacted] care. [redacted] confirmed to the [redacted] counselor that she began the process of placing Grace back into [redacted] care [redacted]
There is no record of [redacted] contacting Montgomery County Office of Children & Youth for assistance. Grace was described by the [redacted] Counselor as a sweet, kind, caring individual, with good grades, positive peer interactions, and positive teacher interactions. Grace was often rewarded at school for good behavior.

July 4, 2016
Grace attended a Fourth of July picnic at [redacted]

July 2016
[redacted] and [redacted] signed a lease for the Quakertown, Bucks County, residence.

July 7, 2016
Grace did not appear for her scheduled appointment at [redacted]

July 8, 2016
[redacted] and [redacted] drove Grace from Glenside to Quakertown in the morning (See Circumstances of Child Fatality for further information.)

July 9, 2016
Date of Death.

July 13, 2016
[redacted] contacted [redacted] and reported that Grace ran away.

August 11, 2016
[redacted] sent a letter to [redacted] stating that if they did not hear back from Ms. Packer or Grace, and an appointment was not made by August 21, 2016, the chart would be closed.

August 22, 2016
Grace discharged from [redacted]

October 27, 2016
A referral was received by [redacted] from a mandated reporter who had contact with [redacted] The reporter stated that [redacted] revealed that Grace was no longer in the home, [redacted]. This was a [redacted] report that was sent to Philadelphia for assessment; however, the outcome of the referral is not known.

October 31, 2016
Grace's body located in Luzerne County.

November 2016-February 2017
Bucks County Children & Youth (BucksCCY)

November 12, 2016
[redacted] arrested for obstruction/endangering. Referral to BucksCCY for safety planning for [redacted]. [redacted]

January 8, 2017
[redacted] confessed to the murder and rape of Grace with the help of [redacted] Both [redacted] were charged and remain without bail in the Bucks County Correctional Facility.

January 9, 2017
BucksCCY received [redacted] report for Grace's fatality. [redacted]

Circumstances of Child Fatality and Related Case Activity:

On November 12, 2016, Bucks County Children & Youth was initially notified of the need for a [redacted] as [redacted] mother was just arrested, and the police wanted to ascertain whether [redacted] and/or [redacted] sibling were victims of abuse. The Agency received few details at that time but was told that [redacted] had been arrested on charges of endangering the welfare of a child due to non-cooperation with the investigation into [redacted], Grace, who had been missing since July. At that time, [redacted] was placed in Montgomery County Correctional Facility. On December 13, 2016, [redacted] custody of BucksCCY. [redacted]

[redacted]

On December 22, 2016, a press conference was held at the Bucks County Courthouse by District Attorneys from Bucks, Montgomery, and Luzerne Counties. Grace Packer's body had been found in Luzerne County, and law enforcement was requesting assistance from the public in providing information to assist in the investigation regarding Grace, who had been missing since July 9, 2016. Shortly thereafter, [redacted] was released from Montgomery County Correctional Facility after [redacted] bail was reduced.

On January 9, 2017, a report was received from [redacted] that Grace Packer had been murdered by her [redacted], and [redacted] Subsequent to the [redacted] referral, the BucksCCY [redacted] began its investigation by requesting and obtaining all relevant past records from the following: Berks County Children & Youth Services, Burke County, North Carolina Department of Social Services, Delaware County Children & Youth Services Lehigh County Office of Children & Youth Services, Montgomery County Office of Children & Youth, Abington Township School District, [redacted]

From law enforcement Affidavits of Probable Cause, it was learned that [redacted] had taken Grace from their Glenside, Montgomery County, residence to their new residence in Quakertown, Bucks County, on July 8, 2016, where [redacted] physically assaulted, sexually assaulted, and raped Grace while [redacted] watched. At one point during the aforementioned, [redacted] left the home to get medicine which [redacted] then gave to Grace to sedate her. [redacted] ultimately bound and gagged Grace, left her in a cedar closet in the third floor attic of the home, and then left the residence. At approximately 3:00 a.m. on the morning of July 9, 2016, [redacted] returned to the Quakertown home where they expected to find Grace dead from the assault, drugs, and excessive heat. When they found that Grace was still alive, [redacted] strangled Grace until she died. Per [redacted] report to the police, the couple packed Grace's body in kitty litter to mask any odor, and she remained in the Quakertown home until mid-October, 2016. On October 11, 2016, police visited with [redacted] in the Quakertown home to do a follow-up investigation. According to the Affidavits of Probable Cause, [redacted] explained to the police that [redacted] and [redacted] were concerned the police would discover Grace's remains, so after the police visit on October 11, they moved Grace's body to a second floor bathroom where they dismembered her limbs. [redacted] reported that [redacted] and [redacted] drove Grace's remains north and disposed of them.

On Monday, October 31, 2016, human remains were discovered in Bear Creek Township, Luzerne County. On Tuesday, November 8, 2016, the remains discovered were identified as those of Grace Packer.

On Friday, December 30, 2016, [redacted] contacted 911 requesting emergency assistance for [redacted] as [redacted] had found [redacted] non-responsive in the bedroom of a home in Horsham Township, Montgomery County. At that time, [redacted] stated [redacted] suspected [redacted] had taken an overdose of pills. Also on Friday, December 30, 2016, in the evening, [redacted] called again to Montgomery County Emergency Communications stating that after the ambulance and police left [redacted] home earlier with [redacted], [redacted] located [redacted] unresponsive in the bathroom of the home. Both [redacted] were taken to Abington Memorial Hospital and admitted for [redacted]

On January 7, 2017, investigators from Bucks and Montgomery Counties were notified that [redacted] admitted to hospital personnel that [redacted] was responsible for the murder of Grace Packer with [redacted] as an accomplice. [redacted] were subsequently arrested and have remained in the Bucks County Correctional Facility since their arrest. [redacted] were charged with homicide, kidnapping, and abuse of a corpse. [redacted] was also charged with rape; [redacted] was charged with conspiracy to commit rape. A trial date is scheduled for both [redacted] in March of 2018.

BucksCCY has pended the final child abuse determination until the conclusion of the criminal proceedings.

STRENGTHS, DEFICIENCIES, AND RECOMMENDATIONS FOR CHANGE:

STRENGTHS

- In compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations:

It appears that all child welfare services were provided in compliance with statutes and regulations. Collaboration occurred in several instances between law enforcement, child welfare, and other community services. On at least one occasion, Grace was interviewed at a child advocacy center with the Multidisciplinary Investigative Team present. The case was also reviewed at internal child welfare critical case meetings. The [redacted] was offered the opportunity to participate in Family Team meetings on several occasions but it appears that they declined. Law Enforcement and child welfare agencies collaborated during child abuse and criminal investigations.

During the three years that this case was open for services in Lehigh County, the same caseworker was assigned to this family allowing for continuity of service. This caseworker was very active and involved with this family as was seen by the extensive case documentation. During the time the case was open in Berks and Lehigh Counties, many community, social service, and other professional services were provided to this family. Additionally many child serving systems such as

school, [redacted] health, and health care were actively involved during various times in this case. Grace received school evaluations and several Individual Educational Plans (IEP) were developed to meet her special needs. Grace also received [redacted] and was receiving [redacted] services, [redacted] Attempts were made by Berks County prior to [redacted] to assure that Grace would continue to have contact with an [redacted] who was not placed in the same home.

DEFICIENCIES

- In compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations:

During the time of the child sexual abuse investigations into [redacted], Grace was placed on an informal basis with [redacted]. [redacted] continued to have access to Grace at [redacted] although it is unclear if any of those contacts were unsupervised. While at her [redacted], Grace revealed sexual abuse by [redacted], who later admitted to [redacted] sexual contact with Grace. [redacted] parents did not believe the allegations by Grace, and it was noted that they exhibited openly hostile and angry behavior to Grace when she was brought to the [redacted] for an interview. Grace was maintained in this home by Lehigh County until her return to her mother's home.

The sexual abuse allegations were [redacted] against both [redacted] yet Grace [redacted] were returned to the care of [redacted] because [redacted] was no longer in the home. The nature of [redacted] involvement in the sexual abuse of another foster child, per [redacted] own admission and documented in the [redacted] evaluation, did not result in the removal of Grace from [redacted] care and did not prevent Grace from returning home. Despite the history of sexual abuse, numerous [redacted] sexual abuse reports, and [redacted] admission of active involvement in sexual abuse of a foster child, Grace and [redacted] were returned to [redacted] care. During the sexual abuse investigation, Lehigh County did not consult with their solicitor or seek court jurisdiction.

The evaluations of [redacted] completed by [redacted] has the potential to be flawed due to the Lehigh County policies that limit information that can be provided for an evaluation. It was reported that Lehigh County could only relay information on the specific allegations involving another [redacted] child and could not relay data on Grace's background or behavior that may have provided more insight into the development of the final recommendations. Lehigh County child welfare and the evaluators reported that the county legal system limits what they are able to provide to evaluators in advance. Additionally, there was not a case conference or team meeting to discuss the findings of the evaluations which may have resulted in further insight into the best next steps for the [redacted]

Even with limited information provided, the evaluators elicited a confession from [redacted] of [redacted] active participation in the sexual abuse of the [redacted] child that did not result in stronger recommendations regarding the safety of Grace [redacted] Both the [redacted] evaluators and the County determined it was safe to return these children home despite the seriousness of the history and [redacted] participation in sexual activity with a [redacted] child.

Burke County child welfare did not view the case as an 'abandonment' or a 'disrupted adoption' when it was brought to their attention by the family caretakers of Grace who could no longer manage her in their home in North Carolina. Therefore, they located [redacted] and arranged for [redacted] to pick up Grace to return to Pennsylvania without any assessment of safety. In fact, they did not feel they had any safety or child welfare concerns at the time [redacted] drove to North Carolina for Grace despite the reports from Grace's [redacted] and Grace's admission of feeling unsafe in the [redacted] home. Burke County did not take custody and thus could not utilize the Interstate Compact process to request an assessment of the [redacted] home. After Grace was residing in Pennsylvania, Burke County requested a home check for the sole purpose of 'closing their case as is standard procedure.'

There were multiple [redacted] allegations and investigations involving the [redacted] throughout the years. These investigations were conducted by various county child welfare agencies and the Pennsylvania Office of Children, Youth and Families Northeast Regional office staff. It was difficult to assess the appropriateness of the outcomes of these investigations as all [redacted] material was expunged. The information regarding the many allegations/investigations was found in case records with minimal information due to expungement requirements. It appeared that one report documented a physical injury to Grace based on her report of pain and inability to sit. However, that report was [redacted] so no other information could be located. With multiple allegations/investigations over several years it would seem that this case should have been thoroughly assessed for the safety of Grace [redacted] and maintained as an open case for a longer period of time. Lastly, as many of the investigations were determined to be [redacted] and expunged, new investigations did not have the history of previous allegations or the insight from previous investigations. It appeared that [redacted] did not provide the history of all prior reports when a new allegation was reported.

The [redacted] were approved as foster parents for adolescents at [redacted], yet [redacted] were placed with their older [redacted] in the home. At that time, [redacted] also worked as a case worker for [redacted] The [redacted] were designated as a [redacted] despite a lack of any evidence that they received special training. [redacted] caseworker reported that the agency did not require any special skills or training to be [redacted] but hoped that foster parents would voluntarily access supplemental training. It appears to be a conflict for [redacted] to be approved as a foster parent at an agency for which she was employed.

[redacted] completed the [redacted] homestudy via Statewide Adoption Network (SWAN) services. The references obtained were from the [redacted] parents, a friend, and an [redacted] caseworker. The caseworker noted that she felt 'flattered' to be asked to be a reference for the family. No objective, independent references were sought. [redacted] noted that the [redacted] would not do well with a 'strong willed or defiant child.' Grace's behavior issues tend to fall into that category, and it was curious why this adoption was deemed as appropriate for her.

The Berks County caseworker stated that the County agency did not make home visits to the [redacted]—only the [redacted] caseworker visited the [redacted] home.

Repeatedly, it was noted that Grace was receiving mental health services yet it seemed that much of it was not focused on the key issues in this child's life. The focus did not seem to be on her [redacted] behavior, her sense of abandonment by her [redacted] when she was sent to North Carolina, or the failure of her [redacted] to protect her from sexual abuse by her [redacted] In one case it was noted that her therapist was an intern rather than a seasoned [redacted] with experience in such severe sexual abuse. While she was [redacted], there appeared to be much time spent with [redacted] who was misrepresenting [redacted] own 'traumatic' past rather than time spent with Grace. Every county child welfare agency noted the lack of resources for children who have been abused or exhibit serious sexually reactive behaviors. It was also noted that more collaboration should occur between [redacted] and the child welfare system prior to the discharge of a child.

Finally, after a thorough review of all case history into this girl's life was conducted the Fatality Team identified many red flags. Due to the overburdened child welfare system, this type of thorough review would be impossible for all complex cases. A review such as this connects the dots and helps to paint a clear picture of the ways that Grace and her siblings may have been better served by all systems involved in their life.

RECOMMENDATIONS

- For changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
- For changes at the state and local levels on monitoring and inspection of county agencies; and
- For changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

It is important to note that the child welfare system as it stands today is overwhelmed. All recommendations stated in this report need to be accompanied with adequate resources and staffing in order to implement

the necessary changes to ensure the safety of children, like Grace Packer, and to maintain best practice standards.

RECOMMENDATIONS FOR CHILD WELFARE PRACTICE

1) Staff should be trained on the importance of viewing the entire case history when assessing risk and safety, not just a "point in time" as reflected by one report.

2) Case documentation should be clear and specific, including but not limited to, documenting who was seen for each visit.

3) Child welfare agencies must have consistent case documentation and organization and not close a case until all documentation/paperwork is complete.

4) County child welfare agencies must provide full case information when referring case to another county child welfare agency and receiving agency must review all information prior to deciding whether or not to accept case for assessment.

5) It is recommended that a protocol be established to assure that all law enforcement only reports (LEO's) received by Children & Youth agencies are reviewed by a supervisor to determine whether there are child welfare concerns embedded in the report.

6) All placements should be determined by the needs of the child. In some cases a child is best served long-term in a community or residential setting. County child welfare agencies should not be penalized for pursuing a more restrictive placement option. Had Grace received the appropriate services and [redacted] care early on, she may not have needed more restrictive settings. However, as she aged, it appeared she could have benefited from a structured residential setting.

7) For cases involving [redacted] care, caseworkers must meet individually with the child or children at a minimum of once every 30 days. If it is a two-parent foster home, caseworker must meet with both parents. In addition, if the 30 day visits are made by a contracted provider agency, the county caseworker must visit the child(ren) and foster parents at a minimum of every 90 days. The definition of quality of contacts should be enforced as defined in Bulletin 3490-08-05, entitled Frequency and Tracking of Caseworker Visits in Federally Defined Foster Care.

8) Case conference/teaming meetings are necessary among all team members following the completion of any evaluations (e.g. psychological, psychosexual, etc.) completed on any family member to assure an understanding of findings and a clear path forward.

9) When professional evaluations are obtained, counties need to clearly document their response to recommendations. Evaluators should receive all family history information in order to adequately assess the impact of findings on child(ren) and family system.

RECOMMENDATIONS FOR CPS/GPS INVESTIGATION PROCESS

1) CPS and GPS reports on all approved foster homes, including both county and private provider homes, must be investigated by regional OCYF staff.

2) OCYF Regional Office CPS investigations shall be conducted in the same manner as county CPS investigations including but not limited to, reviewing history of allegations and criminal history, interviewing all potential collateral contacts, and conducting developmentally appropriate interviews of all children in the home.

3) Abuse investigations in foster and adoptive homes should include interviews of all children currently living in the home and children who were living in the home in the past five years. If an interview is not being conducted, documentation is required as to why the interview did not take place, for example, if the children had previously been interviewed.

4) To allow for quality CPS/GPS investigations by the Region, establish specialized investigation unit that focuses solely on the investigation of licensed homes/facilities.

5) Situations where there are allegations of [redacted], and the offender is not of age designated by CPS law, should be addressed by Multidisciplinary Investigative Teams (MDIT) or Child Advocacy Centers (as available) as required for CPS cases under CPSL.

6) New CPS/GPS referrals on open child welfare cases should be completed by an Intake caseworker separately but collaboratively with the ongoing caseworker and the MDIT as appropriate.

RECOMMENDATIONS FOR FOSTER CARE/ADOPTION PRACTICE

1) Ensure compliance with regulations regarding maintaining of adoption case records.

2) Procedure for obtaining appropriate references for [redacted] applicants should be reviewed by SWAN (Statewide Adoption Network). ([redacted] only references were their parents, a friend, and the caseworker, who was "flattered" to be asked to be a reference.) Independent, non-relative references must be required. Observation/comments by family members

and assigned or previous caseworkers could be solicited but should be in addition to objective references.

3) Consideration should be given to "fresh eyes" being provided when [redacted] parents are being re-evaluated on an annual basis.

4) Provider agency [redacted] care caseworker must inform/communicate with all county agencies placing children in assigned [redacted] homes, monitor progress of all placements, and serve as "gatekeeper" for that home.

5) The caseworker of every child being placed must be provided information on the composition of that foster home, and details of the children placed in that home, to ensure an appropriate match. The county with custody must be made aware of every complaint, referral, or report regarding foster parents or household members including any other foster children in the home.

6) Statewide standards are needed for [redacted]Care including qualifications, "treatment" responsibilities, and training requirements of caregivers.

7) Consideration should be given to whether subsidized adoptions and SPLC (Subsidized Permanent Legal Custodianship) arrangements should receive periodic home visits. SWAN after-care services should be offered where appropriate.

RECOMMENDATIONS FOR CASE RECORDS

1) OCYF needs to create a standardized form that requires every case record to maintain a log stating each referral received, type of referral, disposition, name of assigned caseworker, supervisor and dates. This log should not be expunged.

2) Establishing protocols regarding file organization throughout all counties would assist in Act 33 case reviews, particularly when several counties are involved. When materials are requested for an Act 33 review, all case information must be provided in a chronological order, organized and timely.

RECOMMENDATIONS FOR RESOURCES AND CONTRACTED SERVICES

1) DHS to convene a task force to establish statewide solutions for resource development to meet the unique needs of children in foster care, children who have been sexually abused, and children experiencing trauma and loss, including the critical lack of placement resources for children with complex needs.

2) State OCYF must advocate for mental health treatment resources that meet the unique and complex needs of children who have experienced sexual abuse and/or exhibit sexually reactive behavior, and/or have been adopted at a later age. A review of rates offered via Medical Assistance must be conducted. State advocacy of an increased rate structure should occur or supplemental funds should be made available as to not limit the potential therapy/counseling options.

   Additionally, the state should develop resources of specifically trained, licensed, certified, and experienced therapists/counselors who have the skills needed to meet the needs of this population.

3) An enhanced service array in each community is essential and needs to be explored via collaboration between child welfare, behavioral health care, and other child and family serving systems (i.e. a larger pool of available trained psychologists/social workers to complete child or parent evaluations).

4) All reports from provider or community service agencies need to be reviewed at the contracting county agency for factual consistency. [redacted] foster care reports provided to Lehigh County contained many inaccuracies including wrong dates, and this misinformation was then repeated as truth.

RECOMMENDATIONS FOR CHILDLINE

1) ChildLine should be exempt from expungement requirements. ChildLine records should be accessible only for Act 33 Reviews and future CPS/GPS investigations. The ChildLine reports will be retained by the child welfare agency for internal access only within the HHS integrated system mentioned below under Legislative Action.

2) An automated crosscheck should be completed by the state CWIS system of any child's name referred in a new report through ChildLine with the statewide ChildLine registry. If a child has been the subject of an indicated child abuse report, that child's name should be highlighted or have some designation in the CWIS transmission to a county so that the county will be aware of the child's risk of re-abuse. The crosscheck should occur whether it is a state hotline generated transmission to the county or if it is a county originated transmission; in which case, an auto-reply with the identified history in the registry should be generated back to the county. Ensure that all staff are aware and trained in all facets of statewide data systems.

3) ChildLine must always provide all known data on previous county involvement and criminal history to the county receiving any CPS/GPS referral or LEO.

4) When comparing case note documentation with ChildLine history, dates did not match. Improvement should be made to ensure referral and outcome data congruency between ChildLine and county child welfare agencies.

RECOMMENDATIONS FOR TRAINING

1) Increase child welfare staff training at the "front door" regarding obtaining all information in order to make an informed decision on referral acceptance. Counties should have easily accessible information on family involvement in other child welfare systems to assist in screening decision making.

2) Courts continue to need training on family systems as there still exists misunderstanding of past issues' direct impact on current situations.

3) Increased training is needed for mental health facilities, like [redacted] regarding when it is appropriate to involve the county child welfare agency in planning for a child who may appear to have child welfare needs.

4) Behavioral health providers, both community and residential, as well as those staff providing therapy as part of child-serving agencies, need training in recognizing and treating victims of sexual abuse, including but not limited to sexual reactive behavior, trauma, and the dynamics in families where sexual abuse occurs.

RECOMMENDATIONS FOR STATEWIDE POLICY

1) DHS must assess and establish a policy requiring response to cases when multiple CPS/GPS referrals are received regardless of whether or not allegations were substantiated.

2) A policy needs to be established that requires the state to provide to custodial counties timely information on an investigation and the outcome regarding any allegations of abuse or neglect in a placement setting.

3) Guidelines from OCYF need to be reinforced regarding "conflicts of interest" for employees of a county or private agency seeking approval to become a foster parent. Agencies should develop policies regarding employees not being utilized as resource parents.

RECOMMENDATIONS FOR OVERALL SYSTEMIC CHANGE

1) Implementation of systemic support for child welfare staff who are dealing with a traumatic case is essential in assuring their vicarious trauma is reduced and thus they can continue to effectively deal with this difficult

population. This is also a staff retention issue as was seen by the information received during [redacted] case interviews.

2) Child welfare caseloads should reflect nationally recognized standards of practice as determined by the Casey Foundation and/or the Child Welfare League of America.

3) [redacted] facilities should include child welfare agencies in cases where there are questions about discharge resources and/or safety or risk to a child. (For example, in Grace Packer's case, [redacted] was considering relinquishing custody of Grace, and Grace had severe sexual abuse history that could have warranted a team meeting involving child welfare for planning purposes).

4) Hiring practices for OCYF staff need to be revised to allow for the hiring of applicants with expertise in child welfare including experience in investigating child abuse reports at the county level or in another jurisdiction.

5) Investigate National Electronic Interstate Compact Enterprise (NEICE) as a potential resource for the Commonwealth of Pennsylvania.

RECOMMENDATIONS ON LEGAL ISSUES

1) Court involvement should be considered whenever a county is returning children to a home where an allegation of abuse was Indicated, whether or not the perpetrator is remaining in the home. Court involvement could have been utilized prior to Grace's return to the [redacted] home after sexual abuse was [redacted] for the Delaware County foster child. Whether or not [redacted] won [redacted] or completed [redacted], the evidence regarding [redacted] willing participation in the sexual abuse of the Delaware County [redacted] child would seem to have been adequate to remove Grace and [redacted] from [redacted] care.

2) The entire system for hearing DHS abuse appeals needs to be evaluated, including establishing mandatory requirements for expertise and training in child welfare for Hearing Officers. Appeals hearings courtrooms need to be child friendly, including but not limited to, having a separate place for children apart from perpetrators.

3) Mandated reporters should be held accountable if they fail to report suspected child abuse in accordance with the law.

RECOMMENDATIONS REQUIRING LEGISLATIVE ACTION

1) Any legislation passed should have the appropriate fiscal allocation.

2) Expungement regulations and laws must be re-evaluated to allow for tracking of patterns and review of all history when a new CPS/GPS referral is received. This information is critical in developing a family history of care and safety for a child. The following are recommended as revisions to current expungement regulations:

   - To be able to adequately assess the safety and risk of children, referral and investigation data must be maintained and not expunged for the purpose of county child welfare agency assessment of history when conducting CPS and GPS investigations.
   - Current expungement regulations will apply only to placement on the state registry and for the purpose of child abuse clearances.
   - Confidentiality laws continue to apply to all information released to child welfare agencies on indicated, founded, and unfounded reports, both CPS and GPS in nature.

3) Legal barriers to data sharing between child and family serving systems need to be reviewed. Establish the capacity to share data under the umbrella of the state Department of Health and Human Services. The program must expand upon data maintained in the Master Client Index (MCI). Continue to expand future phases of the Child Welfare Information Solution (CWIS).